



The Health of New Hampshire's Community Hospital System

A Financial Analysis

Speare Memorial Hospital



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An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS ¹	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

¹ Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses) ²
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

² (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire*.

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with \$100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

SPEARE MEMORIAL HOSPITAL, PLYMOUTH, NEW HAMPSHIRE 1993 – 1999 FINANCIAL ANALYSIS

Speare Memorial Hospital is a 33-bed facility, primarily serving residents of Grafton County³. As of 1997, Medicare and private insurers represented the largest percentage of payers for inpatient discharges (42% and 41%, respectively)⁴.

Financial statements are consolidated and represent the hospital and its subsidiaries: Plymouth Hospital Professional Building (PHPB), a 50% owned, for-profit entity that rents professional office space, and, after 1996, Speare Medical Associates (SMA), a wholly owned not-for-profit private physician practice. Collectively these entities will be referred to as the System.

Summary of Financial Analysis 1993-98

The System is financially strong due to high operating and total profit margins over the past six years. These margins were driven by strong operating profitability, which remained high and stable despite slowed growth in the markup of charges over cost relative to growth in payer discounts and contractually (deductible). The system generated capital mainly from equity sources and used it to invest in plant and to increase cash reserves, including marketable securities, resulting in a large amount of liquidity by 1998.

Strong financial performance is sustainable, though the System may not be able to maintain profit margins at the levels of recent years.

Cash Flow Analysis 1993-98

Strong profitability allowed the System to generate most of its cash from internal sources: 60% from net income and 24% from depreciation. Though long-term borrowing was used to augment these internal sources, the amount borrowed (\$2.4M) was just slightly greater than the amount repaid (\$1.8M) over the period, leaving the System with a small amount of additional long-term debt capital.

The System prioritized investment in property, plant and equipment (PP&E), which consumed 56% of the total cash flow over the period. This level of investment (\$7.7M) was more than twice the amount of depreciation expense (\$3.3) and resulted in a young and decreasing age of plant of 6.6 years in 1998, down from a peak of 8.79 in 1994. Close to 45% of the remaining cash flow was used to build liquidity: one-quarter of the cash flow was held as cash reserves, and 18% was invested in marketable securities. This strategy allowed the System to build a large amount of discretionary cash – 311 days as of 1998.

This is a very healthy pattern of cash sources and uses.

Ratio Analysis 1993-1998⁵

Profitability

High profitability was driven by strong performance of the System's central business, the provision of health care services, as evidenced by a strong operating margin. Operating profitability improved dramatically after 1993 following growth in the markup that offset

³ The 1998 American Hospital Association Guide.

⁴ 1997 data from the State of New Hampshire Department of Health and Human Services.

⁵ NH state medians from The 1998-99 Almanac of Financial & Operating Indicators.

deductions to revenue from payer discounts and contractals. Despite slowed growth in the markup adjusted for deductible after 1995, the operating margin remained stable and strong at 8% through 1998.

The contribution of peripheral sources of income, namely investment income, increased steadily and led to the growth in total margins between 1996 and 1998 despite a steady operating income. The nonoperating revenue contribution to the bottom line increased from 31 to 55% from 1996 to 1998, producing total margins of 11 to 15%, respectively. This level of profitability, however, was more dependent on the performance of the stock market in recent years, as realized gains on the sale of investments contributed to 40% of the bottom line in 1998. While this may not be a sustainable source of income, these activities enhanced an already strong operating margin. Financial performance is, therefore, likely to remain strong.

Liquidity

Liquidity is strong; the current ratio indicates that the hospital has more than twice the amount of current resources needed to meet current obligations.

The System has a strong cash position as indicated by the days cash on hand measures. Days cash on hand with short-term sources tripled over the six-year period to reach 96 days in 1998. With the inclusion of unrestricted marketable securities, this measure demonstrates that the hospital has a large amount of liquidity - 311 days of unrestricted cash by 1998. The slight dip in these measures between 1995 and 1996 coincides with the acquisition of the physician practice (SMA). (Note: An accounting policy change adopted in 1997 requiring certain investments to be recorded at market value rather than historical cost may have contributed to the growth in the days cash with all sources measure between 1996 and 1997.)

Overall trends in working capital management were not favorable. The average pay period more than doubled over the period, from 13 to 30 days, though 30 days is a relatively short period in which to pay vendors. This trend is partially explained by the acquisition of SMA in 1996, as this physician practice had a large amount of short-term liabilities. Cash from this source may have been used to manage growth in receivables. The collection of patient account receivables slowed over the period, from 67 to 73 days, which places the System in the lowest tenth percentile in the state in 1997.

Capital Structure

The hospital has a fairly debt-free capital structure as illustrated by the high equity financing ratio (77% in 1998). Dips in this measure in 1995 and 1998 reflect a capital lease obligation in the amount of \$330K and an increase in long-term borrowing of \$2M, respectively. In addition to debt repayment over the period, growth in equity from high profitability contributed to the favorable trends in capitalization. Additionally, the above-mentioned accounting principle change contributed to the growth in this measure between 1996 and 1997 due to the effect of unrealized gains.

Since the system has relatively little long-term debt and strong profitability, it can easily service its principal and interest payments and regularly produces enough cash flow from net income to cover a large percentage of its total outstanding debt.

Charity Care and Community Benefits

Free care reported as charges forgone consistently represented less than 1% of gross patient service revenues until 1998, when this amount doubled. Free care cost did not meet the estimated

value of the System's tax exemption, even with the inclusion of bad debt costs. The hospital reported Medicaid costs that exceeded payment as additional charity care. (Medicaid costs exceeding payment are not allowable under the New Hampshire Community Benefit Statute.) With the inclusion of these amounts to free care costs, the System met the value of its estimated tax benefits.

Footnotes to the financial statements also reported health screenings and educational programs for which no payment was received as additional community benefits, but no costs were reported for these services.

According to the 1998 American Hospital Association Guide facility codes, Speare Memorial Hospital did not offer services, such as a Neo-natal Intensive Care Unit, trauma center, or burn or HIV/AIDS services, that could be considered an additional charitable benefit to the community.

Cash Flow Analysis 1993 – 1999

Between 1993 and 1999, Speare Memorial Hospital generated most of its cash from internal sources. Net income provided 65% and depreciation 25% of cash generated. The main use of cash was investment in property plant and equipment (PP&E) at 62% (\$10M). The investment in PP&E was more than double the depreciation in 1998. In 1999, the average plant life was 6.17 years. This was in the youngest quartile in the state. 14% of cash was designated to cash reserves and 24% was used for investments in marketable securities.

1999 Ratio Analysis

Profitability

The total margin decreased slightly from 15% in 1998 to 14% in 1999. Total non-operating revenue increased from \$1.4 million to \$2.1 million. The operating margin decreased dramatically from 8% to 2%. This was due to a \$434,000 increase in salaries and wages (a 7% increase from the prior year) and a 55% increase in the provision of bad debt. Net patient service revenue did not increase.

Liquidity

The current ratio remained high at 4.76.

Days in accounts receivable increased slightly from 73 days in 1998 to 76 days in 1999. However, the average pay period decreased from 31 days to 27 days. Days current cash on hand decreased from 96 days cash to 69 days. Once board-designated marketable securities were included, the days cash on hand increased from 311 days cash to 318 days. This was 60 days above the 1999 state median.

Capital Structure

The equity financing ratio increased slightly from 77% in 1998 to 80% in 1999. This was due to an increase in the unrestricted fund balance. More than three quarters of the center's assets were financed by equity rather than debt sources. The issuance of new debt of \$2,080,000 in 1998 contributed to a decrease in the center's cash flow to total debt from 10.72 in 1998 to 3.37 in 1999. The debt service coverage with operating income was 4.13 times. The hospital had more than adequate earnings, plus depreciation and interest expense to cover its debt service.

Charity Care and Community Benefits

Between 1998 and 1999, charity care as charges forgone increased from 1.57% to 2.17% as a percentage of gross patient service revenue. Bad debt increased from 3.31% to 4.92%.

Summary

The hospital had a strong financial position. Although its operating margin declined dramatically in 1999, its total margin remained at 14%. In addition, the center had very little debt.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health